

1. Q - Can follow up trauma services be submitted for reimbursement that occurs in the doctor's office?
A – No, follow-up care must be provided in the trauma center hospital.
2. Q - Is there a timeframe that follow up care has to be provided in?
A - No, there is no timeframe but the follow up care has to be related to the original trauma injury.
3. Q – Are D.C. Medicaid patients that are treated in a Maryland trauma center covered by the Trauma Fund because D.C. Medicaid will not reimburse for care delivered outside of Maryland?
A – Yes, a physician can submit to the trauma fund after a denial is obtained from D.C. Medicaid. The MHCC will work with D.C. Medicaid to confirm under what circumstances care could be reimbursed. If care is delivered at the Children's National Medical Trauma Center in Washington, DC, the practice CAN NOT submit a claim to the Trauma Fund if the child is covered by DC Medicaid.
4. Q - If the physician is not reimbursed according to the rules for paying non-contracting physicians that treat a HMO patient (Health Article 19.710.1), can the physician then file for the difference from the trauma fund?
A – No. If a patient has insurance please submit a claim to the plan, regardless if the practice participates. If the plan is providing a PPO policy, the practice will be paid as non-participating provider. If the plan is an HMO, the plan must reimburse under Health Article 19.710.1. If a physician is not reimbursed as required, the physician should contact the Maryland Insurance Administration at 410-468-2340 or 1-800-492-6116. A complaint form is also accessible at www.mdinsurance.state.md.us/jsp/Consumer/FileComplaint.jsp10
5. Q - For out of state Medicaid, in order for the physician to get payment, the physician must enroll with that state in order to get paid, even though the physician does not want to participate. Please explain.
A – The conditions of Medicaid participation vary. At a minimum, the practice must submit a denial from the state Medicaid agency. It may be to the practice's advantage to participate because the physician may treat other non-trauma Medicaid patients for which NO patient is otherwise available.
6. Q - If a service is provided in 2004, does the reimbursement get based on the 2004 Medicare fee schedule or the current fee schedule?

A – The reimbursement is based on the date of service. If the service was provided in 2004, the reimbursement would be based on the 2004 Medicare fee schedule for the Baltimore regional area.

7. Q – When will claims be sent to MHCC for payment from Coresource?
A - All claims will be submitted to the MHCC by the 10th of the following month. The physician's office will receive an EOB from Coresource. The state has 75 days to reimburse.
8. Q - Can Coresource accept the CMS 1500 form instead of the form handed out in the packet?
A – Yes, both forms will be accepted.
9. Q – Does the physician's office have to submit backup documentation along with the claims?
A – No, documentation is not required at the time of submission but should be kept in the event of an audit. The only exception is for DC Medicaid denials.
10. Q - Previously we had a zero in the beginning of the trauma ID number. Is this still required?
A – The claims form requires a 9 character field. The first 2 characters are for the facility code that corresponds to the trauma center that issues the trauma number. The next 6 characters are the trauma registry number. Please insert leading zeros at the beginning of the six character trauma registry number so that all 6 fields are filled. The last character is the constant character 'M'. That character signals to Coresource that a trauma claim has arrived for processing. Failure to include the 'M' will cause the claim to be rejected.
11. Q - Block 14 of the CMS 1500 form asks for "Date of Current Injury". Please explain.
A – This requires the date of the initial trauma injury.
12. Q – In block 2, the name of the patient is required. There are incidences where we realize the name is misspelled after it's on the trauma registry. Should we correct the name?
A – No, please use the name that matches the registry, even if it is incorrect.
13. Q - Please clarify the difference between blocks 1A and blocks 23 on the CMS 1500 form.
A – Both blocks require the same information – the 2 digit trauma center number, the 6 digit trauma registry number and the letter "M".

14. Q - How should anesthesia be reported?
A – Anesthesia must be reported in total units – both base and time units.
15. Q - Does the name have to be signed or can the name be typed?
A – Both are acceptable, typed or written.
16. Q - Block 29, what should be in the amount paid?
A – Either a payment from PIP or money received from the patient out of pocket.
17. Q - If Block 29 is not completed but an EOB is attached, can the claim still be submitted?
A – Yes, Please note that in most cases an EOB with an amount paid would mean the patient is insured and thus not eligible for the Trauma Fund.
18. Q - If a bill comes back “bad address”, or if the person is a “John Doe”, do you still have to make three billing attempts?
A – If there is no record of an address or if mail is returned due to an incorrect address after one attempt, please document this in your files.
19. Q - How quickly will the request for reimbursement be submitted to the Comptroller’s office?
A - All claims will be submitted to the MHCC by the 10th of the following month. The state reimburses within 75 days. MHCC is taking steps to speed up the process.
20. Q - What is the requested procedure for refunds and overpayments?
A – Refunds and overpayments will be adjusted annually. No refunds should go back to Coresource. An annual reconciliation form will be developed. MHCC anticipates that the form will be submitted to all practices that have received payments about January 1 of each year with the form due back in 30 days. Any funds received by practices will be netted against future payments.
21. Q - Will the physician be reimbursed additional money for code 22?
A – No, traditional payment will be reimbursed only.
22. Q - Will a physician be reimbursed for multiple procedures performed during the same visit or surgery?

A – Yes, but the service must be provided by a physician. There will be no reduction for multiple services or extra compensation for complexity.

23. Q - Should we use a second trauma number for follow up care if a new number is assigned?

A – Yes, if one has been assigned. MIEMSS recommends that a new trauma registry number NOT be assigned for treatment of the same trauma injury.

24. Q - Once electronic filing is accepted, how will we know which ID # to use for Coresource?

A – The ID number will be available when electronic filing is available.

25. Q - Will “in-office” audits continue?

A – Yes.

26. Q - Will you continue to request additions and deletions to the trauma physician registry?

A – No, we will no longer be using the physician registry.

27. Q - Are nurse practitioners and physician assistants eligible for reimbursement to the fund?

A – No, only physician services.

28. Q - Can “supervising physician notes” be submitted for trauma services?

A – Notes should not be submitted. A supervision modifier should be used if available. Please retain supervision documentation at your practice as it may be requested during the audit.

29. Q – Block 17 of the CMS 1500 form asks for the name of the referring physician. If this is not known, what should we do?

A – If the name of the physician is not known, please use the name of the trauma center.

30. Q – If the claim is for a “John Doe” and we don’t know the date of birth, what should we use?

A – Leave it blank.

31. Q – In block 24D, does Coresource need the modifiers?

A – Yes, please provide the U1 modifier.

32. Q – If a claim is denied, what is the procedure for submitting an appeal?
A – Appeals should be in writing and must be submitted to Coresource within 60 days from the receipt of a denied claim.
33. Q - If an out of state patient who has Medicaid is treated, but the claim is denied, can we submit this claim to the trauma fund?

A - Yes, you must provide a copy of the denial when submitting your claim to the trauma fund.
34. Q - If an out of state patient is treated and belongs to an out of state HMO in which we do not participate, can we submit this claim to the trauma fund?

A - No other state has imposed a balance billing prohibition on non-contracting providers. A practice must first bill the HMO. If the claim is denied, a practice must bill the patient and follow its standard billing practices. If the practice fails to obtain reimbursement, submit a claim to the Trauma Fund. All billing attempts must be documented and may be reviewed in the event of an audit.
35. Q - What should I do if I am denied reimbursement from a Maryland HMO?

A -If your claim is denied, you have protections under Health Article 19-710.1. Forward documentation to:

**Mr. Steven Orr, Commissioner
Maryland Insurance Administration
525 St. Paul Place
Baltimore, MD 21202-2272**

An appeal of a denial from the Maryland Physicians Trauma Fund should be sent to Maryland Physicians Trauma Fund, c/o Coresource, Inc., 4940 Campbell Boulevard, Suite 200, Baltimore Maryland 21236.

36. Q - Are all claims submitted to the Trauma Fund in excess of \$5000 audited?

A - Any claim in excess of \$5,000 **may** be subject to an audit by Clifton Gunderson. Clifton Gunderson would choose a select sample of your claims for review. Please keep documentation on all attempts to collect.

37. Q - If a patient has insurance and receives payment directly to be used for reimbursing the physician but refuses to comply with the insurance company, can we submit to the fund?

A -Yes, only after following your standard billing practices and documenting all efforts to collect from the patient.

38. Q - What should we do if we are paid by the Trauma Fund, but later receive a payment from a third-party payer or the individual?

A - The state will require practices that submitted claims to the Trauma Fund to file an end-of-year reconciliation statement with MHCC. This statement will ask practices to identify money received from payers and other sources during the year for which Trauma Funds money was previously paid. Any balance will be netted against future payments.